The Dillon Plan for U.S. health care

John B Dillon MD MS BS FACP earned his medical degree in 1943 at the St Louis University School of Medicine. He became a resident at Letterman General Hospital in San Francisco in anesthesia, and became Chief of Anesthesia in 1946. He not only had a long and distinguished career as an anesthesiologist in the California hospital systems but also on the faculty at UCLA, culminating as Professor of Anesthesiology in 1973. He has also been active in organized medicine with the LA County Medical Society, the California Medical Association and the AMA; he served 6 years as a member of the AMA House of Delegates. His CV fills 16 typewritten pages. He has received numerous awards, and he has been published 117 times, writing not only on matters within his field but also on many aspects of medical practice. At the age of 81, he is retired and living in Koloa, Kauai.

John Dillon is still very active, involving himself in many things. With such a background in medicine his opinion carries weight, and we are happy to have him submit in this issue of the *Journal* a guest editorial on health care in the United States. As a long-time anesthesiologist, John has had a unique opportunity to assess the capabilities and vagaries of surgeons in particular, and of physicians in general, while holding the lives of their patients in his embrace.

We hope Dillon's treatise will stimulate others within our noble profession to devote some of their energies to assessing the plethora of proposals now being bandied about nationally — proposals to "change things". We agree with John: That changes, if warranted, or modifications, for certain, should be devised and designed "from below", ie by us in the profession.

We do not endorse the "Dillon Plan" *in toto*; it provides food for thought, however.

J I Frederick Reppun MD
Editor

Starting from the bottom up

There seems to be almost universal agreement that there needs to be changes in the manner in which health care is provided to the people of the United States. Those who seem to disagree with this are the insurance companies, who profit by the status quo, some physicians and other immediate providers of health care. Attorneys who profit by allegations of malpractice and negligence will also be upset when major reforms occur.

The majority of "consumers" believe that changes in health care delivery are necessary. All agree that costs are excessive and the delivery system is uneven and discriminatory; however, there is little agreement as to how to correct the situation.

Most will probably agree that medical care should not be based upon the profit motive; instead, providers should be satisfied with receiving a reasonable and fair compensation. Almost everyone agrees that medical care is now a right. It is generally recognized that, like other things in life, medical care will not always be of the highest quality for all patients because those who provide it cannot always be the best and the brightest. There is always someone at the bottom of the class but nevertheless certifiable as a fully trained physician or other provider. Some hospitals will always be better than others.

However, there must be an acceptable and universal delivery of basic medical care available to satisfy every patient's need, not necessarily his or her wants. Whether certain exotic treatments should be provided for patients, where the improvement gained in life expectancy or in improved function is negligible, would have to be determined. This is an ethical issue.

It is reasonable to believe that the necessary changes will not come from the top. The system is too vast and entrenched. Medicine suffers from a severe narcissus complex. The changes that will come must come from the bottom.

The first proposition that must be accepted is that no patient should ever receive a bill for medical care, nor for prescription drugs (which should all be generic). All costs must be paid through a single carrier, rather than by the vast insurance bureaucracy that now exists, with its monumental overhead and excessive profit.

Financing should be by taxation, eliminating the need for any insurance. Management of the program should be at the state level through a single department. Since all charges would be standardized there would be no incentive to pad bills. Patients would receive the care they need. Charges should be uniform and standardized, both by the individual health care provider and by the hospitals. All health care providers should be salaried and their incomes capped.

The second proposition is that medical education must be modified to accommodate the revised ethic. Medical education should be patient-oriented rather than to disease and science. The education of medical students should be subsidized. For this the student should, upon completion of medical school and 1 year of rotating internship including obstetrics and pediatrics, be obligated to spend 5 years receiving a graduated salary in providing primary health care under supervision. After the 5 years, the physician might apply for residency training or go into research. By this time he or she would be truly a full-fledged physician.

This would obviate specialists with tunnel vision, as is so common today, who are highly trained technicians but with no knowledge or interest in the patient as a whole but only in his or her disease. Specialty training should be shortened. During that training the physician would receive a salary, starting at the last salary level received as a primary care physician and increasing every year by some amount until the residency or

(Continued) ➤

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‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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other training is completed. I believe this system of medical education would not only increase the number of applicants to medical school but also improve their quality.

Nursing education should also be subsidized. Nursing students should be required to spend several years bedside nursing before any specialization leading to a degree would occur. If higher degrees are desired, the nurse should be directed toward medical school. Other providers would receive appropriate subsidized education and training. As with physicians, income would be capped.

The last proposition is that all suits for alleged malpractice, either by omission or by commission, should be settled by mandatory binding arbitration with all legal fees to be paid by the claimant (unless arbitrated), but however derived, capped. At least part of this proposition is in place and being used by some providers. Besides not providing medical care for all, the United States is the only country in the developed world wherein lawyers may charge contingency fees.

John B Dillon MD
Guest editor from Kauai

Rabies

The case report in this issue of the *Journal,* by veterinarian David Sasaki of the State Department of Health and others, gives proof positive of the value of Hawaii's animal quarantine program.

Hawaii's program has withstood assaults from many directions and by many people who are more concerned about their own pets than they are about the lethal scourge of the rabies virus, should it become prevalent in our state and affect the general public. As the authors of this article point out clearly, Hawaii is only one of 4 places where so far rabies is nonexistent; the other 3 are Australia, Great Britain and New Zealand. The other 49 states of the U.S. are *not* —repeat, *not*—free of the dread disease.

The authors, Drs. Sasaki and Sawa, and Messrs. Kobayashi and Middleton of the DoH, and Christensen of the Department of Agriculture, are to be commended for a job well done and for an excellent report: "Rabid bat diagnosed in Hawaii". Included in our commendation are the people of Sea Land Hawaii, the shipping firm, and those from Hawaii Stevedores Inc, without whose immediate and full cooperation the rabid bat might have eluded surveillance.

J I Frederick Reppun MD
Editor

Medicine is not pure science

As the practice of medicine enters the era of the marketplace, it not only has to maintain its status as a science ever striving for credibility, but also as the art of healing. The latter has elicited increasing attention the past decade or two as more and more people — our patients — demand an approach to the whole person, rather than to a body made up of organs and parts. As if that weren't enough, the medical profession needs to become versed in the economics of doing business and abiding by the stacks of rules and regs that govern the marketplace. All of this is rather overwhelming for the doctor who wishes to concentrate purely on helping people recover from their disabilities.

The physician needs a break; he or she needs to have their batteries recharged at intervals.

The conferences that David Elpern has spearheaded on Kauai and Molokai are just that: Moments in which to relax, consider one's professional career from afar and look to the horizon of the future, personally as well as professionally. They almost always include science, art and the marketplace.

In this issue of the *Journal,* we call the reader's attention to Elpern's introductory remarks that he gave to some 125 registrants at "Health Matters," a 4-day conference at beautiful and spectacular Poipu on Kauai.

We noted and reacted favorably to his subtle but not so gentle remarks on the subject of getting accreditation for the registrations from the medical powers that be, namely the HMA and the JABSOM at UH. Those "bean-counters", as he calls them, are a necessity in order to preserve our credibility, we earthlings of dubious honesty, but they are sticklers for rules that rarely let the art supercede the science of medicine.

We like the way David Elpern brings together the physician and the patient becoming better known impersonally nowadays as the health care provider and the consumer (ugh!). We like the way he brings together our essential para-professionals: Nurses, therapists, social workers and others, who often have an intermediary role and are sometimes closer to the patient than is the physician, alas; brings them into the same intimate and friendly milieu of a conference in a beautiful spot where Nature holds sway.

This particular conference took place on a part of Hawaii that is in the national limelight. Hawaii's people are concerned that the projected interceptor missile program funded by Star Wars at the PMRF at Barking Sands will pose a threat to the people and the environment. A pertinent diversion at the conference was in response to a request from Responsible People for Responsible Government, spark-plugged by Liz Freeman. It was an evening session at which Victor Sidel MD, distinguished Professor of Social Medicine at Einstein College of Medicine in New York and a member of the IPPNW delegation that received the Nobel Peace Prize in Oslo in 1985, spoke at the Lihue Parish Hall. He later met with Senator Inouye who promised to do what he could to protect Kauai and its people. Physicians have a social responsibility, no less!

We hope that David will neither quit nor burn out. We urge readers to give the Kauai Foundation for Continuing Education their sincere support.

J I Frederick Reppun MD
Editor